Supreme Court, U.S.
JUN 2 - 2010

No. 09-438

In The Supreme Court of the United States

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC.,
Petitioner,

v.

JOHNELLA RICHMOND MOSES, Personal Representative of the Estate of MARIE MOSES-IRONS, Deceased,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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SUPPLEMENTAL BRIEF FOR PETITIONER IN RESPONSE TO BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

In *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 119 S. Ct. 685, 142 L.Ed. 2d 648 (1999), this Court was asked to entertain the very issue now pending on certiorari—EMTALA's applicability to hospital inpatients—as an alternative argument in support of the Sixth Circuit's judgment in that case. *See* Brief for Respondent, No. 97-53, 1998 WL 649053, at *41-*47; Brief for AHA *et al.* as *amici curiae*, No. 97-53, 1998 WL 649036, at *22-*27. When *Roberts* was argued, the Assistant arguing for the United States stated that the Secretary intended to promulgate a rule to address the issue. Oral Argument Transcript, 1998 WL 846721, at *20-*21.

The Court declined, in the end, to take up in *Roberts* the issue of EMTALA's applicability to hospital inpatients. *Roberts*, 525 U.S. at 253. And it took several years, but the Secretary did issue her promised rule. It is that rule the Sixth Circuit now has declared to be of no effect in its jurisdiction—in conflict with the holdings of federal courts in several other circuits.

The Acting Solicitor General agrees with Petitioner that the Court of Appeals for the Sixth Circuit committed legal error on each of the two questions presented by the Petition. *See* Br. for the United States as Amicus Curiae at 9 (court of appeals "erred"), 13 (court of appeals "erred"), 14 (court of appeals "should have given [the relevant HHS regulation] controlling weight"), 19 (court of appeals' retroactivity

ruling was "wrong"), 21 (court of appeals' "ruling on the retroactivity issue is in error"). Yet he nonetheless is of the view that the Petition should be denied. His recommendations against a grant of certiorari are not well founded.

1. The Sixth Circuit's decision is a classic candidate for certiorari review. The dissent from the denial of rehearing en banc emphasized the "serious conflict" between the panel's decision below and the decisions of other circuits. Pet. App. 35a (Griffin, J., dissenting from denial of rehearing en banc). *Compare Bryant v. Adventist Health Sys.*, 289 F.3d 1162, 1167 (9th Cir. 2002) (statute's "stabilization requirement normally ends when the patient is admitted for inpatient care" unless admission not in good faith) and *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) ("Once EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency condition, the patient's care becomes the legal responsibility of the hospital and the treating physicians.") and *Collins v. DePaul Hosp.*, 963 F.2d 303, 307 (10th Cir. 1992) (no EMTALA violation where patient was screened, admitted, and treated for 26 days) and *Harry v. Marchant*, 291 F.3d 767, 775 (11th Cir. 2002) (en banc) (Barkett, J., concurring) (agreeing that "because [the plaintiff] was admitted as a patient, redress for negligence occurring during her emergency room care is available through state medical malpractice laws, rather than federal law") with Pet. App. 16a ("EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an emergency medical condition to an inpatient care unit") and *Thornton v. Southwest Detroit Hosp.*, 895

F.2d 1131, 1135 (6th Cir. 1990) (suggesting that EMTALA applied to inpatients).

Federal district courts outside of these circuits have likewise studied this entrenched split when examining the scope of EMTALA, and the "vast majority" of them have sided against the Sixth. Pet. App. 35a (Griffin, J., dissenting from denial of rehearing en banc). *See Rivera v. Hospital Episcopal Cristo Redentor*, 613 F. Supp. 2d 192 (D. P.R. 2009) ("Various circuit courts have determined that EMTALA's stabilization requirement is not applicable in situations where an individual is admitted to the hospital for further treatment.") (citing *Harry*, *Bryant*, and *Bryan*); *Morgan v. North Mississippi Med. Ctr., Inc.*, 403 F. Supp. 2d 1115 (S.D. Ala. 2005) (reviewing *Bryant*, *Bryan* and *Thornton* and adopting the approach taken in *Bryant*), *aff'd*, 225 Fed. Appx. 828 (11th Cir. 2007), *cert. denied*, 128 S. Ct. 888 (2008); *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046, 1054 (E.D. Mo. 2005) ("If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation [under EMTALA] ends."); *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp. 2d 437, 447 (E.D. Pa. 2004) ("[T]he most persuasive synthesis of the law on admission as a defense to EMTALA liability is that admission is a defense so long as admission is not a subterfuge."); *Dollard v. Allen*, 260 F. Supp. 2d 1127 (D. Wyo. 2003) (citing *Bryant* and *Bryan* and concluding that EMTALA's stabilization provision does not apply to individuals admitted to the hospital for inpatient care; "once [the hospital] assumed responsibility for Plaintiff's treatment by admitting her to the medical/surgery unit, it assumed liability under state tort law for negligent treatment"); *Scott v. Hutchinson Hosp.*, 959 F. Supp. 1351 (D. Kan. 1997)

(EMTALA no longer applies to admitted inpatient). The split among the federal courts has precipitated a corresponding "shadow split" in the state courts as well. *Compare Preston v. Meriter Hosp.*, 747 N.W.2d 173 (Wis. 2008) (reviewing available federal precedents and concluding that EMTALA screening requirement does not apply to inpatients) and *Causey v. St. Francis Med. Ctr.*, 719 So. 2d 1072 (La. Ct. App. 1998) (same) *with Smith v. Richmond Mem. Hosp.*, 416 S.E.2d 689 (Va. 1992) (citing *Thornton* in support of its conclusion that EMTALA applies beyond admission as an inpatient). And as is evident from the regularity with which this issue has arisen across the country in the last decade and a half, the issue is a recurring one.

The Acting Solicitor General nonetheless argues that the split the Petition identifies—one already extant even when *Roberts* was decided—is "relatively shallow" and should be permitted to "percolat[e]" further. U.S. Br. 15. But the lengthy footnote 7 in the Acting Solicitor General's submission (not to mention the raft of federal district court decisions that go largely untreated therein) suggests that "relatively shallow" split is far deeper and more entrenched than the Acting Solicitor General would have it. *See id.* at 17 n.7 (citing multiple decisions described as addressing but not "squarely deciding" the issue presented in this Petition). To be clear: A conflict over this precise question has been brewing for the last decade and a half. With the Sixth Circuit's decision here, the conflict first presaged with *Thornton* has come to a full boil—it is very real, and certainly fully established. And where the Acting Solicitor General

has acknowledged that the Sixth Circuit's decision was wrong, further "percolation" would serve no benefit.[1]

2. The Acting Solicitor General also posits that the Court should decline review because HHS might "initiate a rulemaking process" to "reconsider" the 2003 CMS regulation that essentially codified *Bryan* and *Bryant* (and expressly rejected *Thornton*). U.S. Br. 18.[2] But the Acting Solicitor General elsewhere recognizes that the policy articulated in CMS's regulation was reaffirmed as recently as 2008. See U.S. Br. 6 n.3. And whatever the likelihood that HHS will in future "reconsider" a policy it only recently articulated and even more recently reaffirmed, this Court should not decline review on the mere theory that the Department might eventually revisit a regulation that one circuit has declared a dead letter, cementing a current circuit conflict in the process.

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[1] Indeed the Solicitor General has recommended the grant of certiorari to resolve conflicts as or more "shallow" as that claimed here. *See, e.g.*, Brief for the United States as Amicus Curiae, *Virginia Office for Protection and Advocacy v. Reinhard* (No. 09-529) (recommending grant of certiorari in case presenting 1 to 1 circuit split).

[2] The Acting Solicitor General suggests that HHS is "committed to promulgating a request for comment in 2010 and a notice of proposed rulemaking in 2011." U.S. Br. 18. But a request for comment is just a request, and a proposed rulemaking is still just a proposal. It took HHS *four years*, after its stated commitment to the effort during the *Roberts* oral argument, see supra at 1, to promulgate a proposed rule addressing EMTALA's application after inpatient admission; to revise the proposal based on extensive comments; and to finally promulgate 42 C.F.R. § 489.24(d)(2). On that time frame, HHS might (or might not) by 2014 or 2015 have implemented a different policy. And in the meantime, the Sixth Circuit's erroneous ruling would stand.

Legal issues of national importance are constantly being considered, and reconsidered, by federal agencies. It would radically hamstring this Court (not to mention countless parties seeking this Court's guidance) if the Court were to refrain from deciding issues that an expert agency already has pronounced upon but may at some future time revisit. The conflict and resulting uncertainty created by the Sixth Circuit exist now. And guidance is keenly needed now to resolve the disagreement among the circuits about the scope and application of EMTALA and its implementing regulations, and to supply needed certainty to physicians and hospitals in their daily practice.

3. The Acting Solicitor General also offers a limited menu of what he calls various "atypical" elements of this case that, in his view, weigh against review. His concerns are misplaced. That this case is "interlocutory" (summary judgment was reversed) is irrelevant. The questions presented are purely of law, and they are completely dispositive of the case. The Acting Solicitor General also soothingly argues that this hospital might yet prevail on remand—after, that is, expending yet more money and time defending against a demonstrably legally deficient claim. See U.S. Br. 19. That hypothetical result is cold comfort to the other hospitals and hospital systems in the Sixth Circuit, who, absent review here and certainly regardless of the outcome on remand, must continue to operate pursuant to the appeals court's concededly misguided interpretation of the law.

The Acting Solicitor General also contends that this Court's consideration of the case could be "color[ed]" by the fact that plaintiff is a non-patient third party,

which presents a potential statutory standing issue. U.S. Br. 20. That is again not so. The court of appeals held that respondent had standing. Petitioner has not challenged that holding, on which (unlike the issues Petitioner *did* raise) there is no split of authority. And the legal question presented here—whether EMTALA applies to inpatients—is simply not affected by the fact that the respondent here was not herself the inpatient.

4. The Acting Solicitor General also substantially underestimates the practical consequences of denying review. *See* U.S. Br. 20.

By extending EMTALA to inpatient care, the Sixth Circuit has created an inconsistent two-tiered system of care, regulation, penalties, fines, and tort litigation—all depending on whether a patient is admitted through the emergency department with an emergency medical condition, or by another route. Patients admitted as inpatients—whether through the ER or by their physician—are protected by state tort law governing medical malpractice, the hospital's Medicare Conditions of Participation, and state quality assurance and licensing laws. But under the Sixth Circuit's decision, patients admitted through the ER with an emergency medical condition are now entitled to another federalized care requirement: ongoing treatment "as may be required to stabilize the medical condition," *i.e.*, so as to ensure that no material deterioration in the patient's emergency medical condition occurs throughout the hospitalization, or an "appropriate" transfer. And for those inpatients admitted through the ER, the federal stabilization requirement apparently applies indefinitely beyond admission, meaning that "stabilizing care" may be required for days, weeks, or months.

Importing EMTALA's "stabilization" standard to hospital inpatients also has the potential to transform every malpractice claim for post-discharge complications by those admitted through the ER into a federal "failure to stabilize" claim under EMTALA. In addition to forcing already strained federal court dockets to accommodate mine-run medical-malpractice cases, such "federal malpractice" claims undermine state tort principles (not to mention thwarting EMTALA's own instruction that the statute's provisions are not to preempt any available state tort law). They are not subject to many procedural state tort reform provisions, including expert-witness limitations, affidavits of merit, shorter limitations periods on malpractice claims, and letters or notices of intent to bring a claim. (For one example, EMTALA's two-year statute of limitations is double the time period for bringing a medical malpractice claim in Ohio.) Peer-review protections also exist in many states to promote the candor needed to ensure participation and effective retrospective review and quality care; but those protections do not apply in federal court.

Extending EMTALA's reach to inpatients also will change the way physicians practice medicine in the inpatient setting. For patients admitted through the ER with an emergency medical condition, protocols would have to be established to track (and ensure EMTALA compliance as to) those patients. Patient complaints related to insufficient stabilizing care or premature discharge while an inpatient will place hospitals at risk for civil fines, substantial expenses in responding to CMS investigations, and potential disqualification from Medicare. Physicians, too, would face civil fines and Medicare disqualification. See 42

U.S.C. § 1395dd(d)(1). The clinical decision to discharge is a matter of physician judgment, not a hospital decision; yet under EMTALA, hospitals will be held directly liable (and potentially excluded from Medicare participation) for the clinical choices of their physicians at the time of patient discharge. EMTALA fines and potential CMS investigations will push physicians toward practicing defensive medicine, lest they risk federal penalty. And much of that additional layer of uncalled-for care—whether needless diagnostic tests or excessive hospital stays—will be unreimbursed, further straining the nation's health care system.

The Sixth Circuit's ruling also poses an enforcement conundrum for HHS itself. The decision establishes a higher bar for EMTALA compliance by hospitals and physicians in the states of Michigan, Ohio, Kentucky, and Tennessee than exists in all other states. CMS's Regional Office in Chicago enforces EMTALA in Michigan and Ohio as well as in Illinois, Indiana, Minnesota, and Wisconsin. The Regional Office in Atlanta enforces EMTALA in Kentucky and Tennessee in addition to Alabama, Florida, Georgia, Mississippi, North Carolina, and South Carolina. Under the Sixth Circuit's decision, the Chicago and Atlanta Regional Offices now have two different EMTALA standards that apply to the states within their respective regions. Similarly, two different standards have been articulated for OIG enforcement—one for hospitals and physicians in Michigan, Ohio, Kentucky, and Tennessee and another for hospitals and physicians everywhere else. And even if HHS were to view itself as not bound by the Sixth Circuit's decision, individuals in those states are still likely to call upon HHS to investigate alleged

EMTALA violations under the Sixth Circuit's holding. At a minimum, then, this disparity between the states (and among states in Regional Offices) will engender unnecessary work for —and risks damaging the reputation of—HHS. For if a hospital within the Sixth Circuit purportedly violates EMTALA by failing to "stabilize" an inpatient, shall HHS investigate? Shall it decline ever to investigate? If the former, how can HHS uniformly enforce its regulations within a Regional Office? And if the latter, how can HHS ignore the declaration of the Sixth Circuit as to the law applicable there?

The practical problems presented by the Sixth Circuit's decision are many, and they are real. The Acting Solicitor General underestimates them.

5. One other path suggests itself after review of the Acting Solicitor General's submission: Summary reversal. The Acting Solicitor General candidly agrees that the Sixth Circuit committed multiple errors. *See* U.S. Br. 9, 13, 14, 17, 19, 21. If this Court declines to give these issues a full treatment on the merits, it should instead summarily reverse the Sixth Circuit's erroneous ruling.

CONCLUSION

For the foregoing reasons, and those stated in the petition, the petition should be granted and the judgment below reversed or summarily reversed.

Respectfully submitted.

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